MISSOURI
DEPARTMENT OF ECONOMIC DEVELOPMENT

Bob Holden
Governor

Division of Professional Registration
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Director

STATE BOARD OF REGISTRATION FOR THE HEALING ARTS
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P.O. Box 4
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866-289-5753
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Tina Steinman
Executive Director

PHYSICAL THERAPIST
INSTRUCTIONS FOR COMPLETING YOUR APPLICATION

FEE - All fees must be submitted to this office in the form of a cashier's check or money order payable on or through a United States bank. Do not send a personal check, corporate check or cash. **FEES WILL NOT BE REFUNDED**.

Licensure Fee.....$50

The Board wishes to stress that you should provide complete details, dates, names, addresses and zip codes as required in your application. Answer all questions. If you do not, the processing of your application may be delayed indefinitely. Please type or print your application in BLACK ink. The following information is provided in order to assist you in answering questions.

QUESTION #1 - Print your legal name as of date of application. If your name has changed from that which is shown on your birth certificate, you will be required to submit one of the following documents for verification:

QUESTION #2 - Provide address to which all licensure material should be sent. Indicate current telephone number.

QUESTION #3 - Indicate date and place of birth. Indicate your social security number and provide the Board with a copy of your social security card. State and Federal law mandates the submission of social security numbers on professional applications.

QUESTION #4 - Indicate intended Missouri practice address. If unknown, please indicate the reason why a Missouri license is needed.

QUESTION #5 - List in chronological order the name and location of each institution attended, beginning with high school. Please indicate the dates of attendance, graduation date and type of diploma or certificate awarded.

QUESTION #6 - State degree received, date degree received, school of graduation and location of school.

QUESTION #7 - List all professional licenses whether active, inactive, temporary or institutional, in order of attainment.

QUESTION #8 - Indicate if you have taken any part of a National Physical Therapy Examination, list date(s), number of times taken and the state(s) in which the examination(s) was given.

QUESTION #9 - Indicate if you have taken a State Board Examination, listing date(s), number of times taken and the state(s) in which the examination(s) was given.

QUESTION #10 - If your answer is "yes" provide complete details on a separate notarized statement. The statement must specify the States, Provinces or Country, the dates and reason(s).

QUESTION #11 - If your answer is "yes" provide complete details on a separate notarized statement. This statement must specify name, address of the association, society, hospital, or agency, date and reason(s) for action.

QUESTION #12 - If your answer is "yes", provide complete details on a separate notarized statement. The statement must specify the States, Provinces or Country, the dates and reason(s).

QUESTION #13 - If your answer is "yes", provide complete details on a separate notarized statement. The statement must specify the States, Provinces or Country, the dates and reason(s).

QUESTION #14 - If your answer is "yes", provide complete details, including names of treating professional(s), institutions, addresses and dates on a separate notarized statement. It will be necessary for you to complete the enclosed *Authorization for Release of Medical Records form* and return it to the Board office.

QUESTION #15 - If your answer is "yes" provide complete details, dates, etc., on a separate notarized statement. This should include States, Provinces, or Country, dates and reason(s).

QUESTION #16 - If your answer is "yes", provide complete details on a separate notarized statement. Furnish a certified court copy (with court seal affixed) of the original complaint(s), the answer(s), and the disposition(s) of the case(s). If the case(s) is still pending, your attorney must submit a letter stating the current status of the case.

QUESTION #17 - If your answer is "yes", provide complete details of arrest, the dates, places and disposition of the case on a separate notarized statement. Furnish a certified court copy, with court seal affixed of the original charge, the judgement, the sentence, and/or the dismissal order, or other such documents which reflects the disposition of the matter.

> This does not include any minor traffic or parking violations. We suggest that if you have ever had an arrest (no matter how minor), you answer the question "yes" on your application and furnish complete details of the incident leading up to and including the arrest and disposition of the case.

QUESTION #18 - If your answer is "yes", provide complete details, dates etc., on a separate notarized statement. Furnish a certified court copy (with court seal affixed) of the original complaint(s), the answer(s), and the disposition(s) of the case(s). If the case(s) is still pending, please so state. If your insurance company paid a claim without a formal case being filed, then include the dates, names of the patient(s) involved, insurance claim number, insurance carrier, and the facts and circumstances surrounding the claim. It will be necessary for you to contact

the insurance carrier handling the claim and authorize them to submit, directly to the Board, all information they have on file regarding the claim.

QUESTION #19 - If your answer is "yes", provide complete details etc., on a separate notarized statement. This should include the States, Provinces, or Country, dates and reasons.

QUESTION #20 - If your answer is "yes", provide complete details, includes names of treating professional(s), institutions, addresses and dates on a separate notarized statement. It will be necessary for you to complete the enclosed *Authorization for Release of Medical Records* form and return it to the Board office.

QUESTION #21 - If your answer is "yes", provide complete details, dates, etc., on a separate notarized statement. This should include the States, Provinces, or Country, dates and reasons.

QUESTION #22 - Provide a recent, unmounted identifiable photograph no larger than 3" x 5". This photograph must be an original. The Board will not accept copies of photographs or magazine clippings. You must sign the oath in the presence of a Notary Public. The Notary Public must complete his/her portion.

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED.

MISSOURI
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BOARD OF REGISTRATION FOR THE HEALING ARTS
3605 MISSOURI BLVD.
P.O. BOX 4
JEFFERSON CITY, MO 65109
TELEPHONE 573-751-0117
TOLL FREE 866-439-3892

PHYSICAL THERAPIST APPLICATION

I HEREBY APPLY FOR A LICENSE TO PRACTICE AS A PROFESSIONAL PHYSICAL THERAPIST IN THE STATE OF MISSOURI.

1. APPLICANT NAME (LAST, FIRST, MIDDLE, SUFFIX, MAIDEN)

2. HOME ADDRESS (PO BOX, STREET, CITY, COUNTY, STATE, ZIP CODE)	TELEPHONE NUMBER

3. DATE OF BIRTH	PLACE OF BIRTH	SOCIAL SECURITY NUMBER

4. PROPOSED MISSOURI PRACTICE ADDRESS

5 EDUCATION - STATE IN CHRONOLOGICAL ORDER THE NAME AND LOCATION OF EACH INSTITUTION ATTENDED, BEGINNING WITH HIGH SCHOOL, THE DATES ATTENDED, AND THE DEGREE RECEIVED, IF ANY.

NAME AND LOCATION OF INSTITUTION	DATES ATTENDED	DEGREE RECEIVED

6. PHYSICAL THERAPY DEGREE/CERTIFICATE RECEIVED	DATE RECEIVED

PROFESSIONAL SCHOOL NAME AND LOCATION

7. ARE YOU CURRENTLY LICENSED, OR HAVE YOU EVER HELD LICENSURE, REGISTRATION, OR CERTIFICATION (PERMANENT, TEMPORARY OR INSTITUTIONAL) TO PRACTICE AS A PHYSICAL THERAPIST OR ANOTHER PROFESSION IN THIS OR ANY OTHER STATE OR COUNTRY? (E.G. PHYSICAL THERAPIST ASSISTANT, NURSE, ETC.)

☐ YES ☐ NO

IF YES, PLEASE LIST BELOW.

STATE	LICENSE NUMBER	DATES HELD	PROFESSION

8. HAVE YOU TAKEN A NATIONAL PHYSICAL THERAPY EXAMINATION (E.G. PES, FSBPT, ETC.)

☐ YES ☐ NO

IF YES, INDICATE THE DATE(S), NUMBER OF TIMES AND STATE(S):

9. HAVE YOU TAKEN A STATE BOARD EXAMINATION?

☐ YES ☐ NO

IF YES, INDICATE THE DATE(S), NUMBER OF TIMES AND STATE(S):

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH THE APPROPRIATE CHECKMARK. IF ANY ARE ANSWERED YES, SEE SEPARATE INSTRUCTIONS.

	YES	NO
10. HAVE YOU, OR ANY LICENSE OR RIGHT TO PRACTICE HELD BY YOU, BEEN RESTRICTED OR DISCIPLINED, SUCH DISCIPLINARY ACTION TO INCLUDE, BUT NOT BE LIMITED TO, REVOCATION, SUSPENSION, PROBATION, CENSURE, OR REPRIMAND, WHETHER VOLUNTARILY AGREED TO OR NOT, BY ANY U.S. STATE, TERRITORY, FEDERAL AGENCY, CANADIAN PROVINCE OR FOREIGN COUNTRY?	☐	☐
11. HAVE YOU HAD ANY DISCIPLINARY OR CORRECTIVE ACTION TAKEN AGAINST YOU, OR HAD YOUR RIGHT TO PRACTICE RESTRICTED, BY ANY PROFESSIONAL ASSOCIATION OR SOCIETY, OR BY ANY LICENSED HOSPITAL OR MEDICAL STAFF OF A HOSPITAL?	☐	☐
12. HAVE YOU SURRENDERED A LICENSE ISSUED TO YOU BY ANY U.S. STATE, CANADIAN PROVINCIAL OR INTERNATIONAL LICENSING AGENCY FOR REASONS OTHER THAN FAILURE TO RENEW?	☐	☐
13. HAVE ANY CHARGES OR COMPLAINTS BEEN FILED AGAINST YOU WITH THE FEDERAL GOVERNMENT, ANY FEDERAL AGENCY OR ANY U.S. STATE OR CANADIAN PROVINCIAL LICENSING OR DISCIPLINARY AGENCY?	☐	☐
14. HAVE YOU BEEN DIAGNOSED OR TREATED FOR ANY MENTAL OR PHYSICAL ILLNESS OR CONDITION THAT HAS HINDERED YOUR ABILITY TO PRACTICE PHYSICAL THERAPY?	☐	☐
15. HAS ANY DISCIPLINARY ACTION BEEN TAKEN AGAINST YOU, OR HAS YOUR AUTHORITY TO PRACTICE BEEN RESTRICTED, BY ANY FEDERAL OR STATE AGENCY INCLUDING, BUT NOT LIMITED TO, MEDICARE OR MEDICAID?	☐	☐
16. HAVE YOU FORFEITED COLLATERAL FOR BREACH OR VIOLATION OF ANY LAW, POLICE REGULATION OR ORDINANCE WHATSOEVER, BEEN SUMMONED INTO COURT AS A DEFENDANT, OR HAS ANY LAW SUIT (OTHER THAN MALPRACTICE) BEEN FILED AGAINST YOU?	☐	☐
17. HAVE YOU BEEN ARRESTED, CHARGED, INDICTED, FOUND GUILTY, OR ENTERED A PLEA OF GUILTY OR NOLO CONTENDERE, IN A CRIMINAL PROSECUTION UNDER THE LAWS OF ANY U.S. STATE OR ANY CANADIAN PROVINCE WHETHER OR NOT SENTENCE WAS IMPOSED, INCLUDING SUSPENDED IMPOSITION OF SENTENCE OR SUSPENDED EXECUTION OF SENTENCE?	☐	☐
18. HAVE YOU BEEN A DEFENDANT IN A LEGAL ACTION INVOLVING PROFESSIONAL LIABILITY (MALPRACTICE) OR HAD A PROFESSIONAL LIABILITY PAID IN YOUR BEHALF OR PAID SUCH CLAIM YOURSELF?	☐	☐
19. HAVE YOU BEEN DENIED A LICENSE TO PRACTICE AS A PHYSICAL THERAPIST OR ANY OTHER PROFESSION OR DENIED THE PRIVILEGES OF TAKING AN EXAMINATION ADMINISTERED BY A U.S. STATE, CANADIAN PROVINCIAL OR INTERNATIONAL LICENSING AGENCY?	☐	☐
20. HAVE YOU BEEN CHEMICALLY DEPENDENT OR TREATED FOR CHEMICAL DEPENDENCY IN THE PAST FIVE YEARS?	☐	☐
21. HAVE YOU EVER MADE APPLICATION FOR LICENSURE IN ANOTHER STATE, PROVINCE OR COUNTRY AND SUBSEQUENTLY WITHDRAWN SAID APPLICATION?	☐	☐

22. APPLICANT'S OATH

State/Province of _____ County/Parish of _____

I, _____ ,hereby certify under oath that I am the person named in this application for a license to practice as a Physical Therapist in the State of Missouri. I have personally read, reviewed and answered each of the questions. All statements I have made are true. I am the original and lawful possessor of and the person named in the various documents and credentials furnished to the Board in connection with the application.

I acknowledge and state that I have read Chapter 334, RSMo, the Statutes, Rules and Regulations, and the instructions that accompanied this application. I have answered all questions in compliance with these instructions and understand that the fee I submitted is nonrefundable.

I further state that by filing this application for a license to practice as a Physical Therapist in the State of Missouri, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for practice as a Physical Therapist, when in the opinion of the Missouri Board such an investigation is deemed necessary. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its content and I further understand that the contents of the investigative report will be privileged unless determined otherwise by court order.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or international), court, association, institution or other organization having control of any documents, records and other information pertaining to me to furnish to the Missouri State Board of Healing Arts any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Missouri State Board of Healing Arts or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application subsequent licensure or practice hereunder.

MUST BE SIGNED IN PRESENCE OF NOTARY	APPLICANT'S SIGNATURE ▶

On this _____ day of _____ , _____ this applicant appeared before me and swore to the truthfulness of this application.

NOTARY PUBLIC EMBOSSER OR BLACK INK RUBBER STAMP SEAL	STATE		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR		**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		

ALL APPLICANTS MUST PLACE AN

ORIGINAL RECENT PHOTOGRAPH

IN THE SPACE PROVIDED

▶

PHYSICAL THERAPIST ACTIVITIES STATEMENT

INSTRUCTIONS: Complete this form providing a chronological listing of all professional and nonprofessional activities from high school graduation to the present date or the last 10 years, whichever is most recent. All dates must be accounted for including all beginning and ending months and years. In CHRONOLOGICAL ORDER, list the position held, complete names, addresses and zip codes of employers. If unemployed or on vacation for more than one month, list your exact activites and locations.

NOTE: The failure to account for all time periods will delay the processing of your application.

DATES				EMPLOYMENT - ACTIVITIES
BEGINNING		ENDING		
MO	YEAR	MO	YEAR	